STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 01 B. WING	05/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/02/12 Facility Number: 012466 Provider Number: 155786 AIM Number: 201014060 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Allisonville Meadows was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety From Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and in all resident rooms. The facility has a capacity of 171 and had a census of 123	K0000	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alledged deficiencies herein. To remain in compliance with all federal and state regulations, Allisonville Meadows has taken or is planning to take the actions set forth in the following plan of correction. The plan of correction constitutes the homes allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated. May 31, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/04/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 4 of 15 doors serving hazardous areas such as fuel fired heater rooms and storage rooms greater than fifty square feet in size used to store combustible materials are equipped with self closing devices on the doors. This deficient practice could affect any resident, staff or visitor in the vicinity of the Central Supply storage room, the Dietary Storage Room in the 400 Hall, the Housekeeping Office in the service corridor and the Mechanical Room in the front lobby. Findings include: Based on observations with the Environmental Supervisor during a tour of the facility from 10:50 a.m. to 12:55 p.m. on 05/02/12, the following areas' entry doors were not equipped with a self closing device; a. the Central Supply storage area measured 154 square feet and is used to store combustible supplies in cardboard	K0029	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected. The central supply room, the dietary storage room, the housekeeping office, and the mechanical room in the front lobby are now equipped with self closing devices. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No residents were affected. The central supply room, the dietary storage room room, the housekeeping office, and the mechanical room in the front lobby are now equipped with self closing devices. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance Supervisor has been re-educated that these areas must have self closing devices on the respective doors identified above. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, what	05/31/2012

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	boxes including undergarment incontinence aids and bandages, b. the Dietary Storage Room in the 400 Hall measured 77 square feet and is used to store combustible dietary supplies in cardboard boxes, c. the Housekeeping Office in the service corridor measured 264 square feet and is used to store combustible comforters and linens, d. the Mechanical Room in the front lobby has one natural gas fired furnace in the room. Based on interview at the time of the observations, the Environmental Supervisor acknowledged each of the aforementioned areas' entry doors were not equipped with a self closing device. 3.1-19(b)		quality assurance program will be put in place. The four doors identified will be monitored weekly for 4 weeks by Enviormental Supervisor to ensure doors are still self closing. the results of the audit will be submitted to the CQI committee for further review and recommendations.	

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K0050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to document fire drills on the third shift for 1 of 4 calendar quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Monthly Fire Drill Report" documentation with the Environmental Supervisor from 9:10 a.m. to 10:50 a.m. on 05/02/12, fire drill records were not available for the third shift for the fourth quarter of 2011. Based on interview at the time of record review, the Environmental Supervisor acknowledged fire drill records for the third shift for the fourth quarter of 2011 were not available for review. 3.1-19(b) 3.1-51(c)	K0050	1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected. The fire drills will be conducted at unexpected times and varying conditions and a coded announcement will only be used between 10pm and 6am and documentation will accurately reflect all fire drills. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No residents were affected. The fire drills will be conducted at unexpectant times and varying conditions and a coded announcement will only be used from 10pm until 6am and documentation will accurately reflect all fire drills conducted. 3. what measures will be put in place or what sytemic changes will be made to ensure that the deficient practice does not recur. Maintenance Supervisor has	05/31/2012

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			been re-educated that the fire drills will be conducted according to schedule at unexpected times and varying conditions and a coded announcement will only be used from 10p to 6am and documentation will accurately reflect all fire drills conducted. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, and what Quality assurance program will be put into place to monitor. Fire alarm reports will be monitored monthly for 3 months by the Executive Director or designee to ensure that the fire drills are conducted according to schedule and unexpected times and varying conditions and a coded announcement is only used from 10pm to 6am and documentation accurately reflects all fire drills conducted. The reults of the audit will be submitted to the CQI committee for further review and recommendations.	

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K0062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement. Findings include: Based on observation with the Environmental Supervisor during a tour of the facility from 10:50 a.m. to 12:55 p.m. on 05/02/12, there were no sidewall	K0062	1. What corrective actions will be accomplished for those residents found to have been affected by the same deficient practice. No residents were affected. We have contacted our fire protection provider and they have come out to install a sidewall sprinkler in the spare sprinkler cabinet for replacement purposes. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No residents were affected. We have contacted our fire protection provider and they have come out an installed a sidewall sprinkler in the spare sprinkler cabinet for replacement purposes. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance Supervisor has been re-educated on the supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. the stock of spare sprinklers shall be proportionally representitives of the types and tempertature rating of the sytem sprinklers. A minimum of two two	05/31/2012

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	sprinklers in the spare sprinkler cabinet, however, sidewall sprinkler heads were observed in the laundry room and throughout the facility. Based on interview at the time of observation, the lack of spare sidewall sprinklers in the spare sprinkler cabinet was acknowledged by the Environmental Supervisor. 3.1-19(b)		sprinklers of each type and temperature rating installed shall be provided. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. What quality assurance programs will be put in place to monitor. The stock of spare sprinklers will be monitored weekly for 4 weeks and then monthly there after, to ensure that all sprinkler spares in the cabinet are present. the maintenance Supervisor will be responsible for this monitoring. The results of the audit will be submitted to the CQI committee for further review and recommendations.	